Angola

2015-16 Multiple Indicator and Health Survey (IIMS)

Key Findings

The Multiple Indicator and Health Survey (2015-16 IIMS) was implemented by the Angola National Institute of Statistics (INE), in direct collaboration with the Ministry of Health (MINSA) and the Ministry of Planning and Territorial Development (MPDT). INE coordinated the survey in collaboration with MINSA and with technical assistance from United Nations Children's Fund (UNICEF) and ICF, through the Demographic and Health Surveys Program, which provides support for population and health surveys in countries worldwide, and with logistical support from the World Health Organization (WHO). The survey was funded by the United States Agency for International Development (USAID), through the President's Malaria Initiative (PMI) and the President's Emergency Plan for AIDS Relief (PEPFAR); the World Bank, through the Ministry of Health's Municipalization Program; UNICEF; and the Government of Angola.

Additional information about the 2015-16 IIMS may be obtained from: Angola National Institute of Statistics (Telephone: +244 222 420 730/1; Internet:www.ine.gov.ao) and Ministry of Health (www.minsa.gov.ao).

Additional information about The DHS Program may be obtained from ICF, 530 Gaither Road, Suite 500, Rockville, MD 20850, U.S.A. (Telephone: +1-301-407-6500; Fax: +1-301-407-6501;
E-mail: info@DHSprogram.com; Internet: www.DHSprogram.com; www.statcompiler.com).

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About the 2015-16 IIMS

The 2015-16 Multiple Indicator and Health Survey, implemented from October 2015 through March 2016, is designed to provide data for monitoring the population and health situation in Angola. It is the first Demographic and Health Survey and fourth Multiple Indicator Cluster Survey conducted in Angola. The objective of the 2015-16 IIMS is to provide current information with regard to the demographic and health situation of women, men, and children, including fertility levels, marriage, sexual activity, fertility preferences, family planning methods, childhood and maternal mortality, maternal and child health, breastfeeding practices, nutrition, malaria, HIV/AIDS, domestic violence, and child wellbeing.

Who participated in the survey?

A nationally representative sample of 14,379 women age 15-49 in 16,109 households and 5,684 men age 15-54 in half of selected households were interviewed in the 2015-16 IIMS. This represents a response rate of 96% for women and 94% for men. The sample design for the 2015-16 IIMS provides estimates at the national and provincial levels, and for urban and rural areas.

Characteristics of Households and Respondents

Household Composition

The average Angolan household has 4.8 members. Thirty-five percent of households are headed by women. The population is very young; more than half of the population (51%) is under age 15.

Water, Sanitation, and Electricity

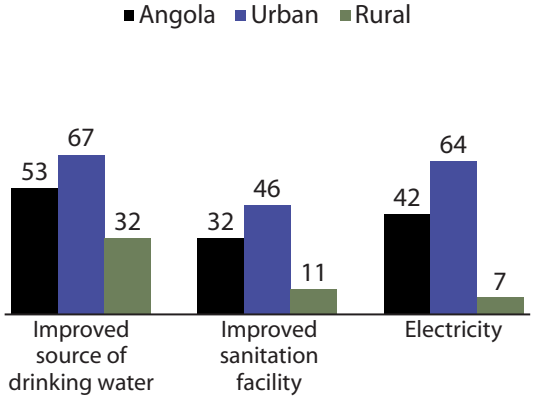
Fifty-three percent of households have access to an improved source of drinking water. Two-thirds of urban households have access to an improved source of drinking water, compared to only one-third of rural households. For 28% of households, it takes 30 minutes or longer to obtain drinking water.

One-third (32%) of households in Angola use improved sanitation facilities. Three in ten households have no sanitation facility.

Nationally, 4 in 10 (42%) households have electricity. The proportion of households with electricity is nine times higher in urban areas (64%) than in rural areas (7%).

Water, Sanitation, and Electricity by Residence

Percent of households with:



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Ownership of Goods

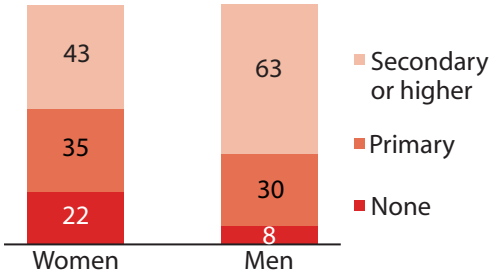
Sixty-three percent of households have a mobile phone, while fewer have a television or radio (51% each). Among modes of transportation, Angolan households have the greatest access to motorcycles (18%) and cars/trucks (11%). Ownership of goods such as mobile phones is higher in urban areas (83%) than in rural areas (31%). In contrast, rural households are more likely to own agricultural land than urban households (82% versus 17%).

Education

Twenty-two percent of women and 8% of men age 15-49 have no education. More than one-third of women and 3 in 10 men attended only primary school. Forty-three percent of women and 63% of men have secondary or higher education. Six in 10 women are literate, compared to 84% of men.

Education

Percent distribution of women and men age 15-49 by highest level of education attended



Fertility and its Determinants

Total Fertility Rate

In Angola, women have an average of 6.2 children. Urban women have a lower fertility rate than rural women (5.3 versus 8.2 children per women). Provincially, fertility varies from 4.5 children per woman in Luanda to 8.6 in Bié.

Fertility is higher among women with no education (7.8 children) than among women with secondary or higher education (4.5 children). Fertility decreases as the wealth of the respondent's household* increases. Women living in the poorest households have an average of 8.5 children, compared to 4.0 children among women living in the wealthiest households.

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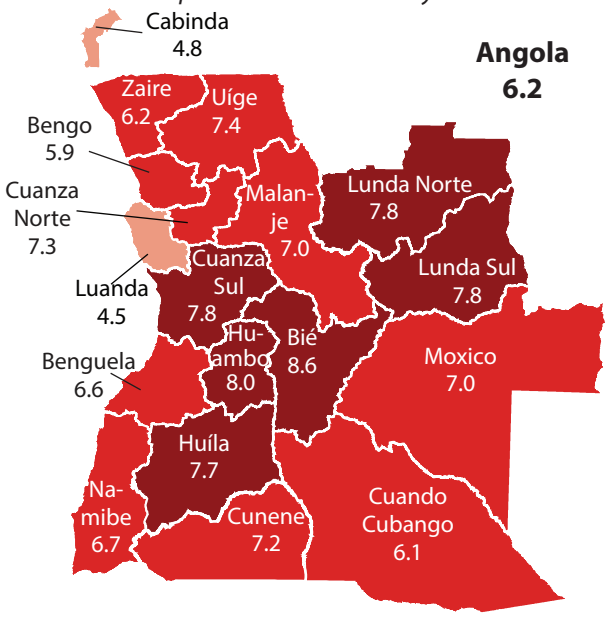
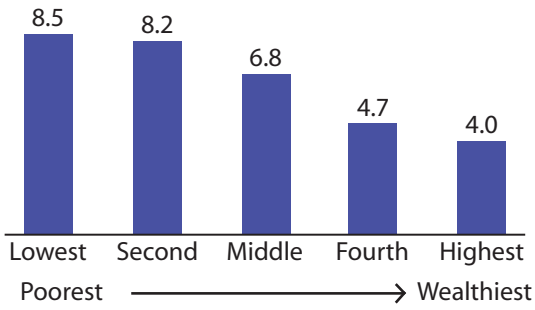
Total Fertility Rate by Province

Births per woman for the three-year period before the survey



Total Fertility Rate by Household Wealth

Births per woman for the three-year period before the survey



*Wealth of families is calculated through household assets collected from DHS surveys—i.e., type of flooring; source of water; availability of electricity; possession of durable consumer goods. These are combined into a single wealth index. They are then divided into five groups of equal size, or quintiles, based on their relative standing on the household wealth index.

Age at First Sexual Intercourse, Birth and Marriage

Angolan women and men tend to begin sexual activity around the same time. The median age at first sex for women and men age 25-49 is 16.6 and 16.7 years, respectively.

Women with more education initiate sex later in life. Women with secondary or higher education initiate sex at 17.6 years, compared with 15.9 years among women with no education. Men show the opposite pattern. Men age 25-54 with secondary or higher education initiate sex at a median age of 16.6 years, while men with no education begin sexual activity a year later at 17.5 years. Almost one-quarter of women and men age 25-49 begin sexual activity before age 15, and two-thirds begin before age 18.

Women have their first child approximately three years after beginning sexual activity, at a median age of 19.5 years. The median age at first birth varies from 18.5 years in Bié to 21.3 years in Moxico.

Women marry one year after their first birth at a median age of 20.5 years. Men marry four years later than women, at 24.4 years. Women with no education and only primary education marry earlier (19.8 years and 19.5 years, respectively) than women with secondary or higher education (22.5 years).

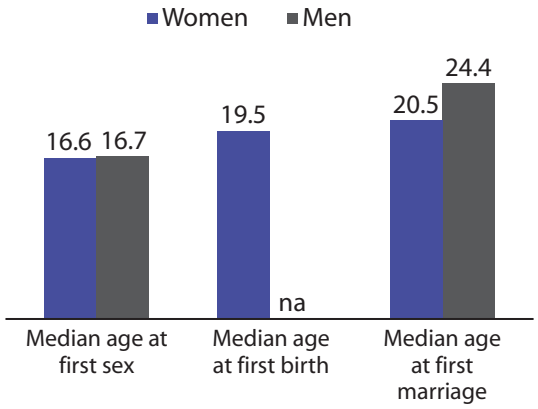
Overall, 30% of women and 7% of men age 25-49 were married before age 18. Currently, 55% of women and 48% of men age 15-49 are currently married.*

Polygamy

Twenty-two percent of women age 15-49 are in a polygamous union and have at least one co-wife. In comparison, 8% of men have more than one wife. Polygamy decreases with household wealth. Thirteen percent of men in the poorest households have two or more wives, compared to 2% of men in the wealthiest households.

Median Age at First Sex, Birth and Marriage

Among women and men age 25-49



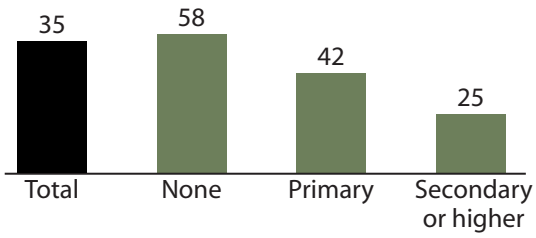
Teenage Fertility

More than one-third (35%) of adolescent women age 15-19 have begun childbearing. Twenty-nine percent are already mothers, and 6% are pregnant with their first child.

Teenage childbearing is twice as high among young women with no education (58%) than among women with secondary or higher education (25%). Provincially, teenage childbearing ranges from 21% in Luanda to 60% in Lunda Sul.

Teenage Childbearing by Education

Percent of women age 15-19 who have begun childbearing



*In the 2015-16 IIMS, currently married refers to respondents who are married or living with their partner.

Family Planning

Knowledge of Family Planning

Seventy-nine percent of women and 95% of men age 15-49 know at least one method of family planning. The male condom is the most well-known method for both women and men (73% and 94%, respectively).

Current Use of Family Planning

Fourteen percent of married women age 15-49 currently use any method of family planning, and 13% use a modern method. The most widely used methods among married women are injectables (5%), the pill (4%), and male condoms (3%).

Use of family planning is higher among sexually active, unmarried women. More than one-quarter (27%) use a modern method of family planning. The male condom (20%) and the pill (4%) are the most widely used methods among this group.

Married women in urban areas are more likely to use modern methods of family planning (18%) than married women in rural areas (only 2%). Provincially, Cuando Cubango has the lowest use of modern methods by married women (1%), and Luanda has the highest (30%). Use of modern methods increases dramatically with economic status. Only 1% of married women from the poorest households use modern methods, compared with 31% of married women from the wealthiest households.

Source of Family Planning Methods

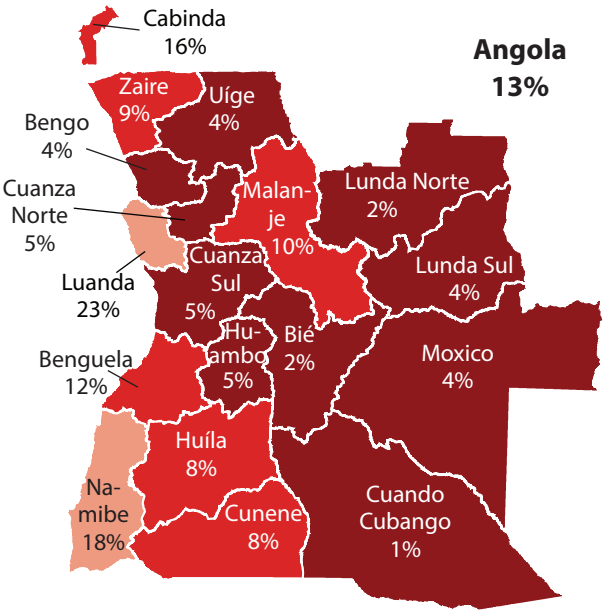
The source of family planning varies by method. Eight-seven percent of users of injectables obtain their family planning from public sources, while 82% of condom users go to the private medical sector (primarily pharmacies). The source for the pill is mixed: 53% of users obtain the method through the private medical sector and 43% from the public sector.

Family Planning

Percent of married women age 15-49 using family planning

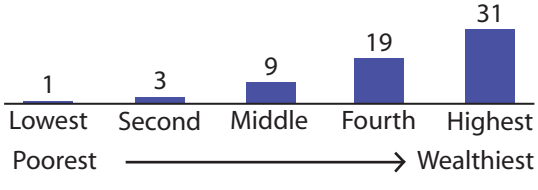
Current Use of Modern Methods by Province

Percent of married women age 15-49 using a modern method of family planning



Current Use of Modern Methods by Household Wealth

Percent of married women age 15-49 using a modern method of family planning



Demand for Family Planning

More than one-third (35%) of married women age 15-49 want to delay childbearing (delay a first birth or space another birth) for two or more years. Additionally, 17% of married women do not want any more children. Women who want to delay or stop childbearing are said to have a demand for family planning. The total demand for family planning among married women in Angola is 52%.

Demand for Family Planning Satisfied by Modern Methods

The total demand for family planning includes both met and unmet need. Met need is the percent of married women who are currently using family planning. In Angola, 14% of married women use family planning (13% use modern methods and 1% uses traditional methods). Unmet need for family planning is defined as the proportion of married women who want to delay or stop childbearing but are not using family planning. Nearly 4 in 10 married women (38%) have an unmet need for family planning: 26% want to delay childbearing, while 12% want to stop childbearing but are not using family planning.

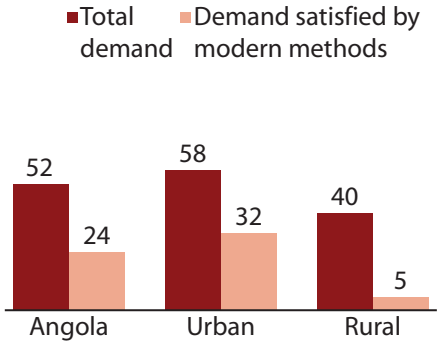
Demand satisfied by modern methods measures the extent to which women who want to delay or stop childbearing are actually using modern family planning methods. The results of the 2015-16 IIMS show that one-quarter of the demand for family planing is satisfied by modern methods.

Women in urban areas have a higher demand for family planning (58%) than women in rural areas (40%). Urban women are also more likely to have their demand for family planning satisfied by modern methods (32%) than rural women (5%).

Demand satisfied by modern methods also increases with household wealth, from 3% among women in the poorest households to 48% in the wealthiest households.

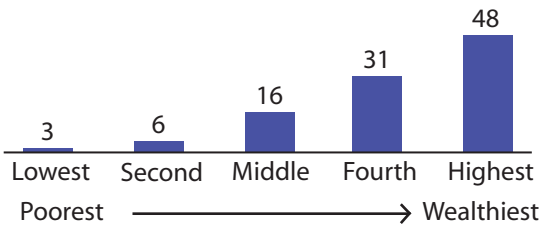
Demand for Family Planning and Demand Satisfied by Modern Methods by Residence

Among married women age 15-49, percent with demand for family planning and demand satisfied by modern methods



Demand Satisfied by Modern Methods by Household Wealth

Among married women age 15-49, percent with demand for family planning satisfied by modern methods



Informed Choice

Family planning clients should be informed about the side effects of the method used, what to do if they experience side effects and told about other available family planning methods. Seven in ten women using modern methods were informed about side effects, 6 in 10 were informed about what to do if they experienced side effects, and nearly three-quarters were informed about other available family planning methods.

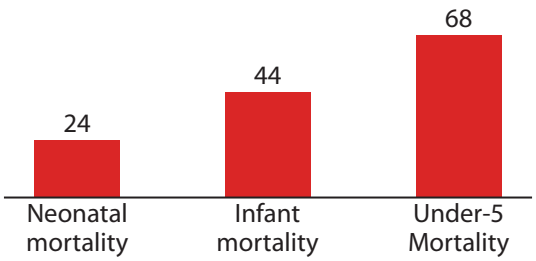
Childhood Mortality

Mortality Rates

Angola's neonatal and infant mortality rates for the five-year period before the survey are 24 and 44 deaths per 1,000 live births, respectively. The under-5 mortality rate is 68 deaths per 1,000 live births. This means that 1 in every 15 children dies before their fifth birthday.

Childhood mortality

Deaths per 1,000 live births for the ten-year period before the survey

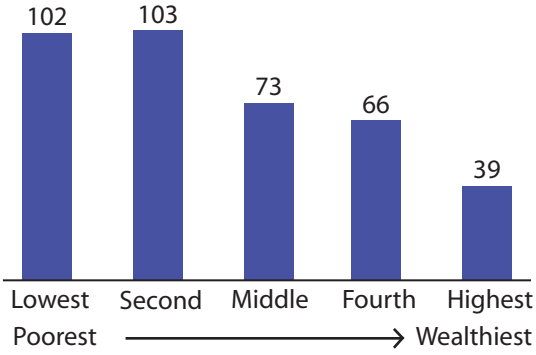


Mortality Rates by Background Characteristics

Mortality rates differ by residence, province, and household wealth for the ten-year period before the survey. Children in rural areas are more likely to die before their fifth birthday (98 deaths per 1,000 live births) than children in urban areas (68 deaths per 1,000 live births). The under-5 mortality rate is 2.5 times higher among children in the lowest two wealth quintiles than among children in the highest quintile (102 and 103 deaths per 1,000 live births in the first two quintiles versus 39 in the highest quintile).

Under-5 Mortality by Household Wealth

Deaths per 1,000 live births for the ten-year period before the survey

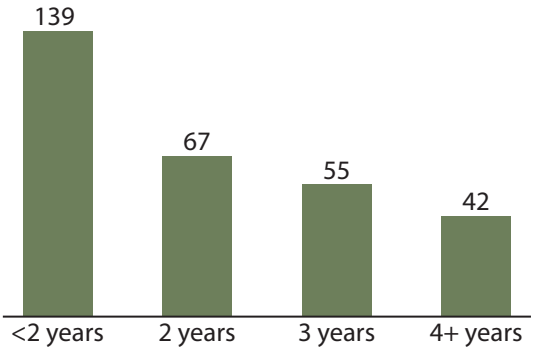


Birth Intervals

Spacing children at least 36 months apart reduces the risk of infant death. The median birth interval in Angola is 30.8 months. Under-5 mortality decreases as the interval between births increases. The findings of the IIMS show a much higher rate of under-5 mortality for children born less than 24 months after their siblings (139 deaths per 1,000 live births) compared with longer intervals. Overall, one-quarter of children are born less than 24 months after their siblings.

Under-5 Mortality by Previous Birth Interval

Deaths per 1,000 live births for the ten-year period before the survey



Maternal Health Care

Antenatal Care

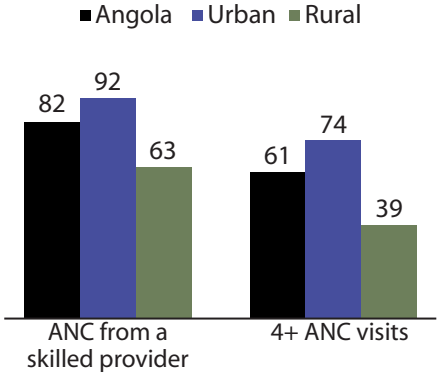
Eight in ten (82%) women age 15-49 received antenatal care (ANC) from a skilled provider (doctor, nurse or midwife). Although coverage of ANC is 92% in urban areas, it is only 63% in rural areas. Eighteen percent of women in Angola did not have any ANC visits.

The timing and quality of ANC are also important. Despite relatively high coverage of ANC in general, less than two-thirds of women (61%) women made four or more ANC visits. Only 40% made their first visit during their first trimester, as recommended.

Three-quarters of women took iron tablets or syrup during pregnancy. Two-thirds of women's most recent births were protected against tetanus. Among women who attended ANC for their most recent birth, 86% had their blood pressure measured, 82% had a urine sample, and 85% had a blood sample taken to check for anemia, urine protein, sugar and signs of infection.

Antenatal Care and Number of Visits by Residence

Percent of women age 15-49 who had a live birth in the five years preceding the survey who had:



Delivery and Postnatal Care

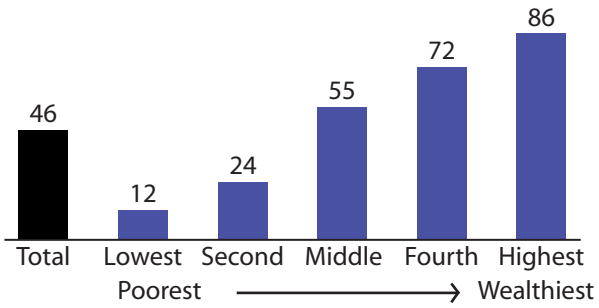
Less than half (46%) of births in Angola take place in health facilities (primarily in the public sector). Conversely, 53% of births occur at home. Half (50%) of births are assisted by a skilled provider.

Health facility births are more common in urban areas than in rural areas (65% vs. 17%). Women in the wealthiest households are much more likely to give birth in a health facility than women in the poorest households (86% vs. 12%). Provincially, health facility births range from 17% in Bié to 86% in Zaire.

The days and weeks after birth are a critical phase in the lives of mothers and their newborns. Less than one-quarter of women received a postnatal checkup in the first two days after giving birth, and 62% did not receive any postnatal checkup. One in five (21%) newborns received a postnatal check within two days of birth.

Health Facility Deliveries by Household Wealth

Percent of live births in the five years before the survey that occurred in a health facility



Pregnancy-related Mortality

The 2015-16 IIMS asked women about deaths of their sisters to determine pregnancy associated with pregnancy and childbearing. The pregnancy-related mortality ratio is 239 deaths per 100,000 live births (confidence interval of 164 to 313). In other words, for every 1,000 live births in Angola during the seven years before the 2015-16 IIMS, approximately two women died during pregnancy, during childbirth, or within two months of childbirth.

Child Health

Basic Vaccination Coverage

Three in ten children age 12-23 months received all basic vaccinations—one dose each of BCG and measles and three doses each of DPT-containing vaccine and polio. Overall, 18% of children age 12-23 months received no vaccines.

Basic vaccination coverage increases with mother's level of education, from 16% among children whose mothers have no education to 51% among children whose mothers have secondary or higher education. A similar pattern exists by household wealth. Basic vaccination coverage ranges from 13% among children from the poorest households to 57% among children from the wealthiest households. Vaccination coverage is lowest in Cuando Cubango (8%) and highest in Luanda (50%).

Age Appropriate Vaccination Coverage

According to the 2015-16 IIMS, 13% of children age 12-23 months received all age-appropriate vaccinations—the eight basic vaccinations plus polio 0 at birth, two doses of rotavirus vaccine, and three doses of pneumococcal vaccine. For children age 24-35 months, appropriate vaccinations also include a second dose of the measles vaccine. Only 9% of children in this age group received all age-appropriate vaccines.

In addition, half (49%) of children age 12-23 months received a yellow fever vaccine.

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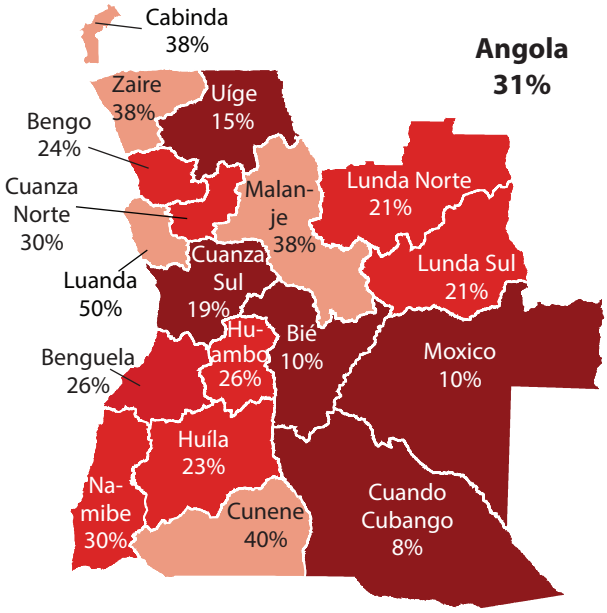
Vaccination Coverage by Province

Percent of children age 12-23 months who received all basic vaccinations



Childhood Illness

In the two weeks before the survey, 3% of children under age five were sick with cough and rapid breathing, symptoms of acute respiratory infection. Of these children, half (49%) were taken to a health facility or provider for advice or treatment.

Sixteen percent of children under age five had diarrhea in the two weeks before the survey. Diarrhea is most common among children age 6-23 months (27%) and least common among children age 48-59 months (6%). Less than half (45%) of children with diarrhea were taken to a health facility or provider for advice or treatment.

Children with diarrhea should receive oral rehydration therapy (ORT), which includes prepackaged oral rehydration salts, recommended home fluids and increased fluids. Fifty-three percent of children with diarrhea received ORT. However, 3 in 10 (29%) children with diarrhea did not receive any treatment.

Feeding Practices and Supplementation

Breastfeeding and the Introduction of Complementary Foods

Breastfeeding is very common in Angola: 95% of children are breastfed at some point. Early initiation of breastfeeding is important for the mother and child. Almost half (48%) of children were breastfed within the first hour of life. Eleven percent of children received something other than breastmilk in the first three days of life, contrary to recommendations.

WHO recommends that children receive nothing but breastmilk (exclusive breasfeeding) for the first six months of life. Thirty-eight percent of children under six months are exclusively breastfed. Exclusive breastfeeding decreases as children age. Among children age 0-1 month, exclusive breastfeeding is 3.6 times more common than among children age 4-5 months (62% vs. 17%).

The median duration of breastfeeding for children born in the three years before the survey is 18.7 months. For exclusive breastfeeding, the median duration is 3.1 months.

Complementary foods should be introduced when a child is six months old to reduce the risk of malnutrition. Three-quarters of children age 6-8 months are breastfed and receive complementary foods.

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Use of Iodized Salt

Micronutrients are essential vitamins and minerals required for good health. Iodine is an important micronutrient for physical and mental development. Fortification of salt with iodine is the most common method of preventing iodine deficiency. Nine in ten households have iodized salt. The presence of iodized salt is higher in urban households (95%) than in rural households (80%).

Vitamin A and Iron Supplementation

Vitamin A, which prevents blindness and infection, is particularly important for children. In the 24 hours before the survey, three-quarters (75%) of children age 6-23 months ate foods rich in vitamin A. Only 6% of children age 6-59 months received a vitamin A supplement in the six months before the survey.

Iron is essential for cognitive development in children, and low iron intake can contribute to anemia. Six in ten children age 6-23 months ate foods rich in iron the day before the survey, and only 1 in 10 children age 6-59 months received an iron supplement in the week before the survey.

Pregnant women should take iron tablets for at least 90 days during pregnancy to prevent anemia and other complications. One-third of women age 15-49 took iron tablets or syrup for at least 90 days during their last pregnancy.

Nutritional Status

Children's Nutritional Status

The 2015-16 IIMS measured children's nutritional status by comparing height and weight measurements against an international reference standard. More than one-third of children under five (38%) are stunted, or too short for their age. Stunting is an indication of chronic undernutrition. By province, stunting ranges from 22% in Cabinda to 51% in Bié. Stunting decreases with increasing mother's education and household wealth.

Wasting (too thin for height), a sign of acute malnutrition, is far less common (5%). In addition, 1 in 5 children (19%) are underweight, or too thin for their age.

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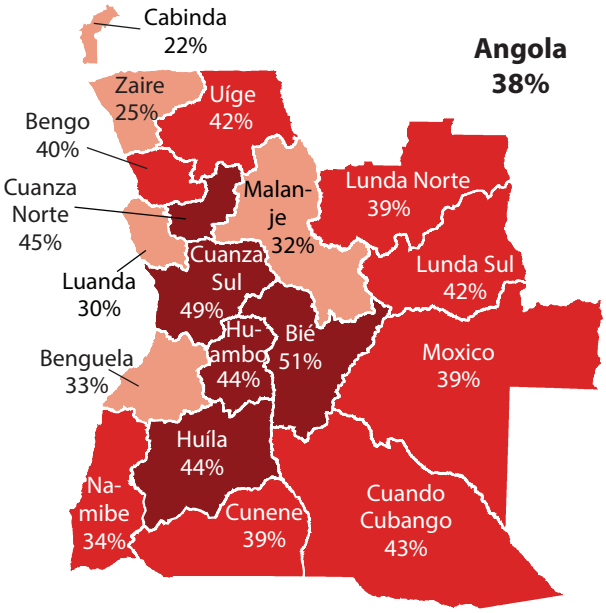
Anemia

The 2015-16 IIMS also tested children age 6-59 months for anemia. Overall, almost two-thirds (65%) of children are anemic. Two percent of children are severely anemic, while the remaining anemic children have mild or moderate anemia.

Anemia is most common in children age 6-8 months (83%) and 9-11 months (82%). Anemia ranges from 50% in Lunda Sul to 77% in Cuando Cubango.

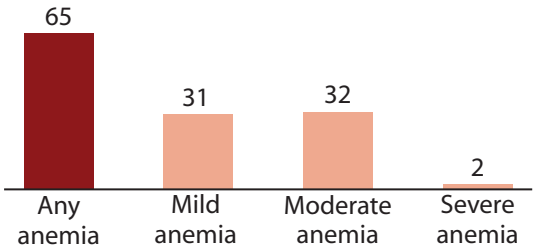
Stunting by Province

Percent of children under age five stunted, based on 2006 WHO Child Growth Standards



Anemia Prevalence in Children

Percent of children age 6-59 months with anemia



Malaria Prevention

Mosquito Nets

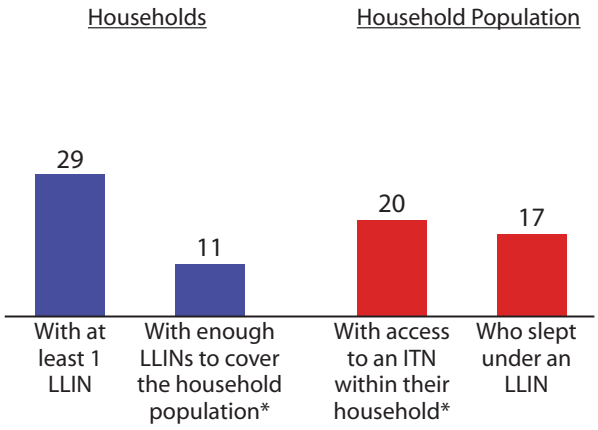
Three in ten (31%) households own at least one insecticide-treated net (ITN). Almost all ITNs in Angola are long lasting insecticidal nets (LLINs); 29% of households own at least one LLIN. More than half of household mosquito nets were obtained through a mass distribution campaign. Ownership of LLINs varies from 7% in Moxico to 45% in Namibe.

Only 1 in 10 households own enough LLINs to cover each household member, assuming one net is used by two people. Overall, 20% of the population in Angola has access to an ITN. Seventeen percent of the household population slept under an LLIN the night before the survey. Use of LLINs varies by province, ranging from 5% in Moxico to 31% in Cabinda.

Children and pregnant women are most vulnerable to malaria. Overall, 20% of children under five and 21% of pregnant women slept under an LLIN the night before the survey. Within households that have at least one ITN, 61% of children and 68% of pregnant women slept under an ITN.

Ownership of, Access to, and Use of Nets

Percent of:



*Assuming 1 net covers 2 people

Indoor Residual Spraying (IRS)

Two percent of households received IRS in the past year. IRS is a targeted intervention, and Huambo has the highest coverage (5%). Nearly one-third (32%) of households either own at least one ITN or benefited from IRS in the last year.

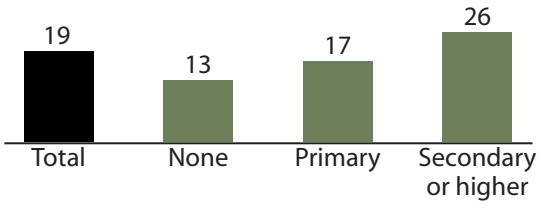
Intermittent Preventive Treatment of Pregnant Women (IPTp)

Malaria during pregnancy contributes to low birth weight, infant mortality, and other complications. To prevent malaria, pregnant women should receive IPTp (at least three doses of SP/Fansidar during ANC visits). While more than one-third (37%) of pregnant women received two or more doses of SP/Fansidar, only 19% received three or more doses.

IPTp increases with education. Only 13% of women with no education received three or more doses of SP Fansidar during their last pregnancy, compared with 26% of women with secondary or higher education.

Intermittent Preventive Treatment during Pregnancy by Education

Percent of women age 15-49 with a live birth in the two years before the survey who took 3+ doses of SP/Fansidar and received at least one during an antenatal care visit



Fever in Children

In the two weeks before the survey, 15% of children had fever, the primary symptom of malaria. Treatment or advice was sought for half of these children, and one-third of them had blood taken from a finger or heel for malaria testing.

Artemisinin-based combination therapy (ACT) is the recommended drug for treating uncomplicated malaria in children in Angola. Among children under five with fever in the two weeks before the survey who took an antimalarial, 77% received ACT.

Prevalence of Fever, Malaria, and Low Hemoglobin

Malaria Prevalence

Children age 6-59 months in 50% of selected households were eligible for malaria testing by rapid diagnostic test (RDT) in the 2015-16 IIMS. According to the RDT results, 14% of children in Angola tested positive for malaria (*P. falciparum*. *P. vivax* or both).

Malaria is ten times more prevalent among children from the poorest households (greater than 20% in the first two quintiles) than among children from the wealthiest households (2%). Prevalence is also greater in rural areas (22%) than in urban areas (8%). By province, malaria prevalence ranges from <1% in Cunene to 40% in Moxico.

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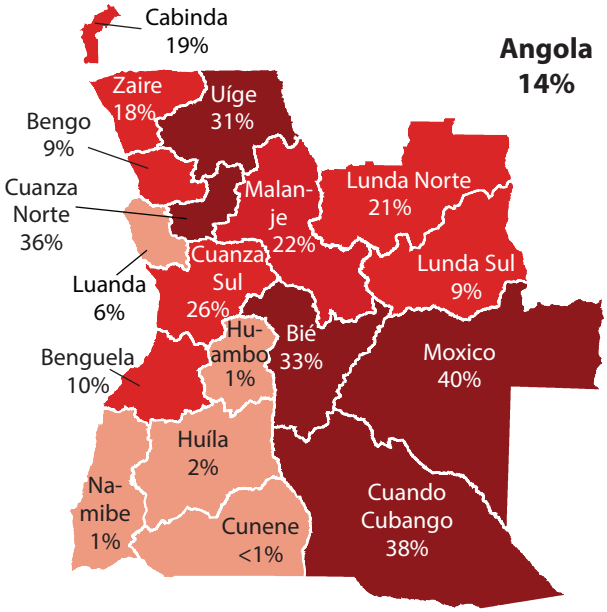
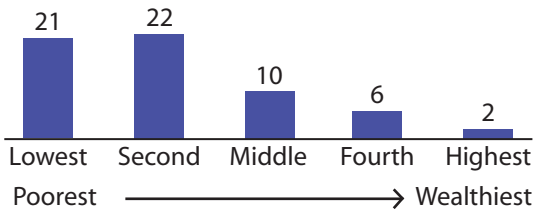
Malaria Prevalence by Province

Percent of children age 6-59 months who tested positive for malaria by rapid diagnostic test (RDT)



Malaria Prevalence by Household Wealth

Percent of children age 6-59 months who tested positive for malaria by RDT



Low Hemoglobin Prevalence

Moderate-to-severe malaria-associated anemia (hemoglobin less than 8 g/dl) affects 6% of children age 6-59 months. Prevalence of malaria-associated anemia is highest among children age 12-17 months (9%), children from the poorest households (7% in each of the first two quintiles) and children whose mothers have no education (8%).

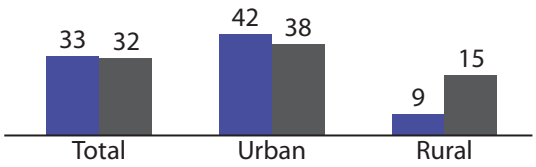
HIV Knowledge, Attitudes, and Behaviors

HIV Knowledge among Youth

Young men are more likely than young women to know about the various HIV prevention methods. Six in ten (62%) women and 7 in 10 (69%) men age 15-24 know that the risk of HIV can be reduced by using condoms and limiting sex to one uninfected partner. Furthermore, more than one-third of both young women (37%) and young men (36%) reject the two most common misconceptions about HIV and say that a healthy looking person can have HIV. Together, these elements make up comprehensive knowledge of HIV. Thirty-three percent of young women and 32% of young men have comprehensive knowledge of HIV. For both young women and men, comprehensive knowledge is higher in urban areas and among those with secondary or higher education.

Comprehensive Knowledge of HIV* Among Youth

Percent of women and men age 15-24 years



**Comprehensive knowledge means knowing that consistent use of condoms during sex and having just one uninfected faithful partner can reduce the chance of getting HIV, knowing that a healthy looking person can have HIV and rejecting the two most common local misconceptions (that HIV can be spread through mosquito bites and that someone can be infected through sharing a meal with someone with HIV).*

Knowledge of Prevention of Mother-to-Child Transmission (PMTCT)

More than half of women (57%) and men (53%) age 15-49 know that HIV can be transmitted during pregnancy, during birth, or through breastfeeding. A slightly higher proportion (58% of women and 62% of men) know that transmission can be reduced if the mother takes special medication during pregnancy.

Multiple Sexual Partners

Having multiple sexual partners increases the risk of contracting HIV and other sexually transmitted infections (STIs). A small percent of women (2%) and 18% of men had two or more sexual partners in the year before the survey. Among women and men with two or more partners in the past year, 24% of women and 30% of men used a condom at last sexual intercourse. Men in Angola have more sexual partners in their lifetime than women (6.7 vs. 2.0).

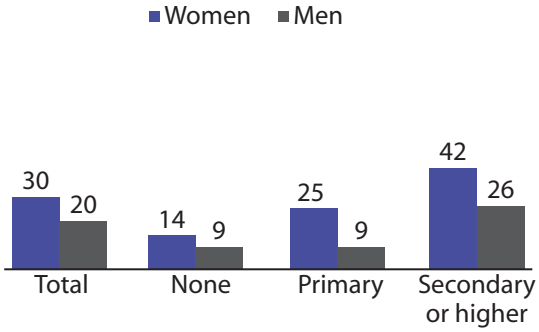
HIV Testing

Two-thirds of women and 7 in 10 men know where to get an HIV test. Less than half of women and one-third of men have ever been tested for HIV and received the results. On the other hand, half of women and two-thirds of men have never been tested for HIV.

In the 12 months before the survey, 3 in 10 women and 2 in 10 men were tested for HIV and received the results. Recent HIV testing increases with education for both women and men. Among women with a live birth in the two years before the survey, 37% were counseled and tested for HIV and received the results.

Recent HIV Testing by Education

Percent of women and men age 15-49 who were tested for HIV in the 12 months before the survey and received their results



HIV Prevalence

HIV Prevalence

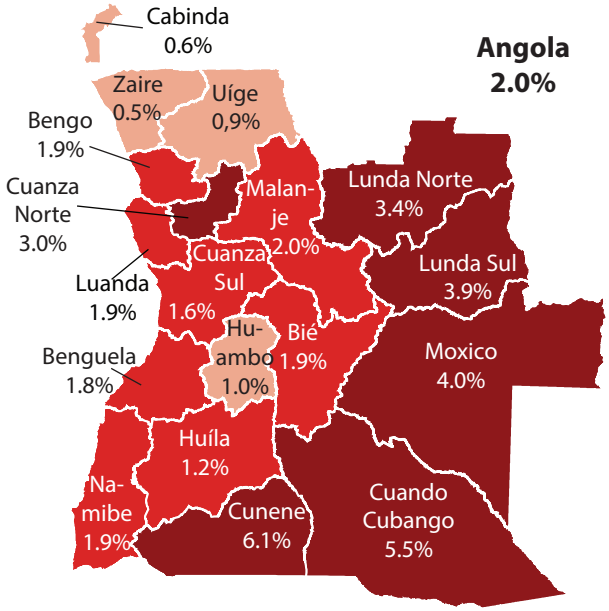
HIV prevalence data were obtained from blood samples voluntarily provided by women and men interviewed in the 2015-16 IIMS. Of the 7,346 women and 5,714 men age 15-49 eligible for testing, 90% of women and 85% of men provided specimens for HIV testing.

Overall, 2.0% of Angolans age 15-49 are HIV-positive. HIV prevalence is higher among women (2.6%) than men (1.2%). By residence, HIV prevalence is higher among women in urban areas (3.0%) than rural areas (1.7%). Among men, there is very little difference in prevalence by residence. Prevalence is slightly higher among men in rural areas (1.4%) than men in urban areas (1.2%). HIV prevalence varies by province, ranging from 0.5% in Zaire to 6.1% in Cunene.

Among women, HIV prevalence is lowest at age 15-19 (0.8%) and highest at age 35-39 (4.3%). Among men, prevalence is also lowest at age 15-19 (0.6%) but highest at age 40-44 (2.7%).

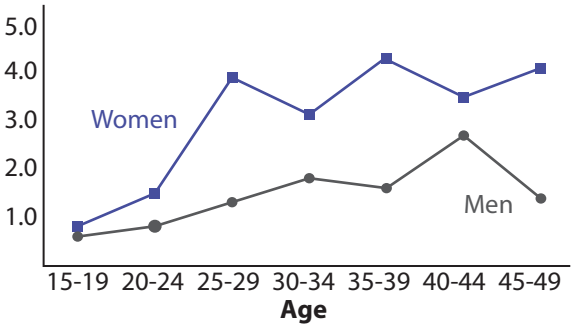
HIV Prevalence by Province

Percent of women and men age 15-49 HIV positive



HIV Prevalence by Age

Percent of women and men age 15-49 HIV-positive



HIV Prevalence among Youth

Overall, 0.9% of Angolan youth age 15-24 are HIV-positive. HIV prevalence is higher among young women (1.1%) than among young men (0.7%). By residence, HIV prevalence among youth is twice as high as in urban areas than in rural areas (1.1% vs. 0.5%). This difference is more pronounced among young women; 1.4% of young women in urban areas are HIV-positive, compared with 0.5% of young women in rural areas.

HIV prevalence is higher among young women who are divorced/separated/widowed (5.7%) than young among women who have never been married (0.9%) or are currently married (1.3%).

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Women's Empowerment

Employment

Three-quarters of married women and 9 in 10 married men age 15-49 were employed in the seven days before the survey. The majority of employed women and men are paid in cash (55% and 73%, respectively). However, 30% of women and 12% of men are not paid for their work.

Four in ten women who are employed and earn cash make joint decisions with their husband on how to spend her earnings, and the same proportion make these decisions on their own. Almost 7 in 10 women report earning less than their husbands.

Participation in Household Decisions

The 2015-16 IIMS asked married women about their participation in three types of household decisions: her own health care, making major household purchases, and visits to family or relatives.

Married women in Angola are most likely to have sole or joint decision making power with regard to visiting family or relatives (88%) and major household purchases (81%). Three-quarters of women participate in decisions about their own health care. Overall, 65% of married women participate in all three decisions. Seven percent do not participate in any of the three decisions.

Problems in Accessing Health Care

Seven in ten women in Angola report at least one problem in accessing health care. Sixty-three percent of women had difficulties getting money for advice or treatment, and 52% had problems with the distance to the health facility.

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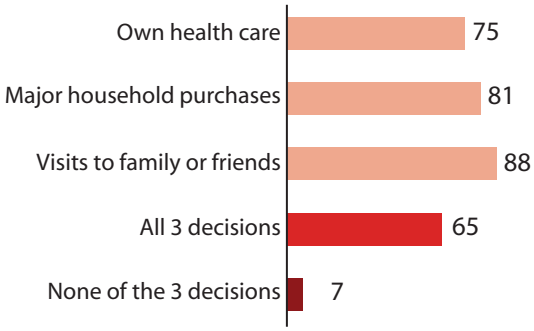
Women's Participation in Decision-Making

Percent of married women age 15-49 who usually make specific decisions by themselves or jointly with their husband



Domestic Violence

Attitudes toward Wife Beating

One-quarter of women and 2 in 10 men age 15-49 agree that a husband is justified in beating his wife for at least one of the following reasons: if she burns the food, argues with him, goes out without telling him, neglects the children, or refuses to have sex with him. The most common reason for both women and men to agree that wife beating is justified is if a wife neglects the children (16% and 11%, respectively) and if a wife argues with her husband (15% of women and 11% of men).

Experience of Physical Violence

Almost one-third (32%) of women age 15-49 have experienced physical violence since age 15. In the past year, 22% experienced physical violence. Experience of physical violence after age 15 is greater among women who are employed and paid in cash (37%) than among unemployed women (29%) and women who are employed but not paid with cash (28%).

Among ever-married women who have experienced physical violence since age 15, nearly three-quarters (73%) reported that their current husband/partner committed the violence. Among never-married women, the most common perpetrator of physical violence is their mother/stepmother (31%).

Experience of Sexual Violence

Eight percent of women age 15-49 have ever experienced sexual violence. Experience of sexual violence is greater in urban areas than in rural areas (9% vs. 6%). Five percent of women experienced sexual violence in the last 12 months.

Violence during Pregnancy

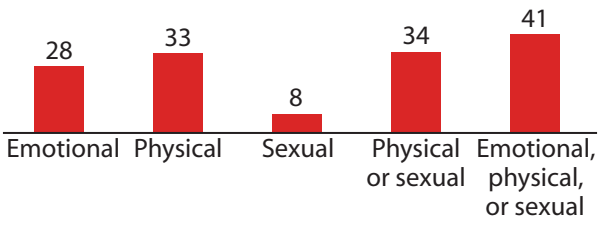
Violence during pregnancy may threaten not only a woman's well-being but also her unborn child. Six percent of women who have ever been pregnant experienced violence during pregnancy.

Spousal Violence

One-third (34%) of ever-married women age 15-49 experienced spousal violence, whether physical or sexual. Experience of spousal violence ranges from 11% in Cuando Cubango to 57% in Malanje. One-quarter (26%) of ever-married women experienced spousal violence within the past year.

Spousal Violence

Percent of ever-married women age 15-49 who have ever experienced specific types of spousal violence



Children's Status

Birth Registration

Just one-quarter of children under five had their birth registered with civil authorities. Birth registration is twice as common in urban areas (33%) as in rural areas (14%).

Access to Education

Seven in ten children age 6-11 attend primary school. Secondary school attendance is lower for both females and males of school age. Four in ten children age 12-18 attend secondary school. Boys are more likely to attend secondary school (43%) than girls (37%). For both sexes, secondary school attendance is higher in urban areas than in rural areas.

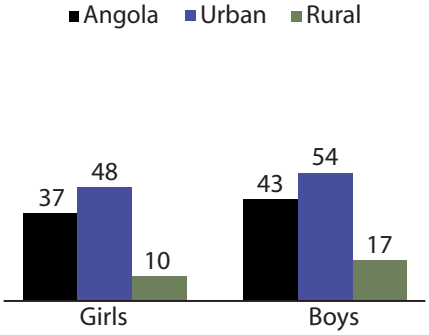
Child Labor

Among children age 5-11, child labor is defined as at least one hour of economic activity, 28 or more hours of household chores, or any work in dangerous conditions. Among children age 12-14, child labor is defined as at least 14 hours of economic activity, 28 or more hours of household chores, or any work in dangerous conditions. Finally, among children age 15-17, child labor includes at least 43 hours of economic activity, at least 43 hours of household chores, or any work in dangerous conditions.

Twenty-three percent of children age 5-17 are engaged in child labor. Twelve percent have worked in dangerous conditions.

Secondary School Net Attendance Ratio by Residence

Percent of the de facto household population age 12-18 currently attending secondary school



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INDICATORS

		Residence	
Fertility	**Angola**	**Urban**	**Rural**
Total Fertility Rate (TFR)	6.2	5.3	8.2
Median age at first sex for women age 25-49 (years)	16.6	16.9	16.0
Women age 15-19 who are mothers or currently pregnant (%)	35	29	49
Family Planning (among married women age 15-49)			
Current use of any method of family planning (%)	14	20	2
Current use of a modern method of family planning (%)	13	18	2
Total demand for family planning (%)[1]	52	58	40
Demand satisfied by modern methods (%)	24	32	5
Maternal and Child Health			
Women age 15-49 who received at least one antenatal visit from a skilled provider (%)[2]	82	92	63
Births delivered in a health facility (%)	46	65	17
Births assisted by a skilled provider (%)[2]	50	68	21
Children age 12-23 months who received all basic vaccinations (%)[3]	31	40	17
Nutrition			
Children under five who are stunted (%)	38	32	46
Children age 6-59 months with anemia (%)	65	65	65
Childhood Mortality (deaths per 1,000 live births) [4]			
Infant morality rate	*44*	43	61
Under-5 mortality rate	*68*	68	98
Malaria			
Households with at least one LLIN (%)	29	29	29
Children under five who slept under an LLIN the night before the survey (%)	20	22	18
Pregnant women age 15-49 who received 3+ doses of SP/Fansidar, at least one during an ANC visit (IPTp) (%)	19	24	11
Malaria prevalence by RDT among children age 6-59 months (%)	14	8	22
HIV/AIDS (among women and men age 15-49)			
Women who were tested for HIV in the last 12 months and received the results (%)	30	37	13
Men who were tested for HIV in the last 12 months and received the results(%)	20	23	11
Total HIV prevalence (%)	2.0	2.1	1.5
HIV prevalence among women (%)	2.6	3.0	1.7
HIV prevalence among men (%)	1.2	1.2	1.4
Women's Empowerment and Domestic Violence (among women age 15-49)			
Married women who participate in household decisions (%)[5]	65	67	62
Ever-married women who have experienced spousal violence (%)[6]	34	35	32

[1]Total demand is the sum of met need (current use) and unmet need (married women who do not want any more children or want to wait at least two years before their next birth but are not currently using a method of family planning). [2]Skilled provider includes doctor, nurse or midwife. [3]Fully vaccinated includes BCG, measles, three doses each of DPT and polio vaccine (excluding polio vaccine given at birth). [4]Figures are for the ten-year period before the survey except for the national rate, in italics, which represents the five-year period before the survey. [5]Women are considered to participate in household decisions if they make all three of the following decisions alone or with their husband: their own health care, major household purchases, and visits to family or friends. [6] Spousal violence includes physical or sexual violence.